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I. EXECUTIVE SUMMARY

Rapid shifts in the health care market have led consumers to demand assurances that the quality of care delivered and the level of protections afforded to them be optimized in Health Maintenance Organizations (HMOs) and other forms of managed care. During the past few years in particular, states have enacted many laws intended to address managed care limits on access to providers and services. However, regardless of the content and scope of new legislation, consumer protections depend on an impartial authority that can validate compliance with the law. The traditional regulation of insurance through the State Corporation Commission's Bureau of Insurance (BOI) was intended to address issues such as licensure, solvency, trade practices, and conduct in the marketplace. HMOs and other forms of managed care provide more than health insurance; they also provide a delivery system for care, and the BOI recognized the necessity for an expanded scope of oversight to address medical and clinical issues. Until very recently the Virginia Department of Health (VDH) has not been active in assuring the quality of care in HMOs, and it has never had authority to conduct quality of care examinations in other forms of managed care organizations (MCOs).

The 1997 General Assembly took a comprehensive approach to quality protections and passed House Bill 2785 (HB 2785, Appendix A), which required that the State Health Commissioner examine the quality of care plans and enrollee complaint systems of HMOs. In addition, it directed the State Health Commissioner to study the quality of health care services delivered in HMOs and other MCOs and recommend the "appropriate role of the Commonwealth in monitoring and improving the quality of care in managed care plans . . . ." The following report reviews and analyzes selected federal and state statutes and regulations governing quality of care and grievance protections for Virginians in managed care plans. While it focuses on HMOs, this report also explores other forms of managed care, such as preferred provider organizations (PPOs).

In an attempt to involve all parties affected by this review, a study group was formed consisting of relevant state agencies,[1] consumers and representatives from the health care industry.[2] The study group addressed several questions. First, what is the current role of the Commonwealth in monitoring and improving the quality of care in HMOs and other forms of managed care? Second, what private sector activities are currently being undertaken to assure high quality of care in HMOs and other forms of managed care? Third, how adequate are the current public and private mechanisms to assure high quality in MCOs? Fourth, should all managed care entities be held accountable for quality of care protections? Fifth, what is the appropriate role of the Commonwealth in monitoring and improving quality of care in managed care organizations?

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[1]Departments of Health Professions, Medical Assistance Services, and Health, and the Bureau of Insurance.

[2]Virginia Hospital and Healthcare Association, Virginia Association of HMOs, Medical Society of Virginia, Virginians for Patient Choice, and Virginia Chamber of Commerce.

More than a dozen separate analyses were undertaken to provide responses to the study questions, involving standard research methods such as statutory analyses, interviews, focus groups, surveys, and selective literature reviews. VDH contracted with the University of Virginia, Department of Health Evaluation Sciences (UVA/DHES) to conduct objective research to supplement the analyses developed by VDH. In particular, UVA reviewed the current quality assurance plans and complaint procedures in managed care plans. UVA also worked with The Southeastern Institute of Research, Inc. (SIR) to conduct a random survey of Virginians to determine consumers' awareness of their rights and responsibilities regarding complaint procedures for their health plan.

The working definition of quality used by the Study Group was adopted from Virginia's health facilities regulatory program. Specifically it derives from the definition contained in the *State Medical Facilities Plan* (12VAC5-230). The scope of the definition applies to seven components of quality recognized by the health care industry as appropriate areas for state oversight during a Round Table on *The Quality of Care in Network-Based Health Delivery Systems* convened by the State Health Commissioner in August 1996. These "consensus" components are: (1) complaint resolution and consumer satisfaction; (2) access and availability; (3) prevention; (4) credentialing; (5) consumer/provider education and awareness; (6) outcome measures and accountability; and (7) improvement of community health. These "consensus" components are the focus for analysis in this report. This review assesses whether the Commonwealth has sufficient authority for monitoring and improving the managed care health plans' policies, procedures, and programs affecting these components of quality. However, there are unresolved issues about the definition and the meaning of the "consensus" components.

Consumers should have a realistic understanding about the number of Virginians who will benefit from enhanced protections and of the level of quality that the Commonwealth can assure them. Consumers need to take prudent steps to educate themselves about their rights and responsibilities. There are several important reasons why this is so:

> State oversight of quality is limited to about 25 percent of the population in Virginia. Federal laws governing Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and most important, a large portion of employer-sponsored health benefit plans, limit actions that the Commonwealth can take.
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> ERISA (Employee Retirement Income Security Act of 1974) health plans that are self-funded by employers are exempt from state oversight and regulation. Thus, state statutes and regulations addressing managed care protections will not affect individuals in ERISA plans. The Joint Commission on Health Care (JCHC) has estimated that one third of privately insured individuals are covered by ERISA self-funded plans.
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> Ideally, the public and private sectors will work together to assure high quality of care in the market. Current laws do not appear to provide adequately for oversight of quality, but it is important that the Commonwealth balance the legitimate demand for choice, access,

and quality with the need to encourage innovation and cost containment by insurers.

Although the current laws appear to address many of the appropriate areas of quality, this report concludes that there are deficiencies in the laws and regulations that need the attention of the General Assembly. The Commonwealth currently has inadequate oversight mechanisms to determine whether health plans are performing in accordance with defined statutes and regulations or with standards these health plans set for themselves. This report concentrates principally on improving current law governing systems-level safeguards. The three general areas that relate to the components of quality and are targeted for improvements include: (1) quality of care assurance/monitoring and improvement, (2) consumer awareness and education, and (3) complaint resolution. The most significant findings of this report are as follows:

Oversight laws have until recently focused on HMOs without including other forms of managed care. It is important that all Virginians enrolled in managed care have the same level of protection. State oversight should be extended on the basis of the functions performed by all insurers.

The *Code of Virginia* requires the State Health Commissioner to examine quality assurance and enrollee complaint systems developed by HMOs, but does not provide adequate authority to address deficiencies. The current Memorandum of Agreement (MOA) between the BOI and the VDH cannot resolve this limitation. The authority granted to the BOI is insufficient to address problems of quality.

More can be done to educate consumers about their health insurance plans. Insurers, providers, consumer groups, patient advocates and purchasers need to develop innovative private-sector methods to educate their constituencies about the existing protections and how they can benefit from them. VDH can assume an educational role limited to assisting and guiding enrollees confused about how to "navigate" themselves through the internal complaint process of their health plan. Finally, providing more information to enrollees about utilization appeals at the time of denial of care and/or through other subscriber communications could be a useful means of educating policy holders.

Chapter 54 of Title 38.2 of the *Code of Virginia* (Chapter 54) contains requirements for a particular type of grievance protection relating to an insurance company's utilization review (UR) or medical necessity decisions. The latter type of grievance is perhaps the most important protection for providers and patients in managed care plans. The BOI lacks regulatory authority for this oversight function, as well as the medical expertise to carry it out. The report presents a possible role for VDH with regard to the regulatory oversight of Chapter 54 appeals.

Private sector initiatives to assure quality have had a significant impact on HMOs. Employers' interest in quality of managed care has given impetus to the development of accreditation standards and outcome measures for managed care plans. However,

national trends suggest that, for employers, quality is a consideration secondary to cost. Private accreditation organizations recommend against states substituting private accreditation of health plans for state oversight obligations; nevertheless, opportunities exist to integrate private accreditation into state oversight of managed care.